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The Effectiveness of Communication Training as Compared to Traditional Group Psychotherapy in an Inpatient Population

Patricia Ruth Murray
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THE EFFECTIVENESS OF COMMUNICATION TRAINING AS COMPARED TO TRADITIONAL GROUP PSYCHOTHERAPY IN AN INPATIENT POPULATION

by

Patricia Ruth Murray

A thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
Degree of Master of Arts

Western Michigan University
Kalamazoo, Michigan
August 1978
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Patricia Ruth Murray
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Abstract

A communication training group was compared with a traditionally-oriented therapy group in order to assess the effectiveness of communication training in increasing appropriate communication responses. It was hypothesized that the communication training group would demonstrate a greater change in communication skills. Nine subjects, one female and eight males, were selected to participate in the study. These Ss were selected from a list of 30 patients who were judged as appropriate for group therapy. They were then randomly directed to either the communication or traditional group. Before the initial group session a written pretest was administered. Each group met twice a week for five weeks. At the conclusion of the training, postmeasures were taken from each group. These measures included a written posttest, and observations of verbal and nonverbal behavior in a role play situation. Results demonstrated no significant difference in treatment between the communication group and the traditional group. Both groups experienced an increase in appropriate communication responses as measured by the written test. Only the communication group showed an improvement in communication responses as measured by the role play situations. The author concluded that refinement in outcome measures in this study would be needed to reach a better understanding of the effectiveness of communication training.
THE EFFECTIVENESS OF COMMUNICATION TRAINING
AS COMPARED TO TRADITIONAL GROUP PSYCHOTHERAPY
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Introduction

Within the last decade a great deal of attention has centered on interpersonal communication patterns and on how these patterns effect interpersonal relationships. The initial exploration of this area focused on the training of professionals and para-professionals to respond to others in an empathic, warm, and genuine manner. It was emphasized that "by hearing affective messages and in turn responding to them, the helper is communicating not only acceptance of these emotions, but permission for the client to experience and own these feelings" (Okun, 1976).

As experimentation continued, it was realized that individuals not involved in the helping professions could also benefit from communication training. Programs have recently been developed which are oriented toward the non-professional. Gordon (1970) has devised a Parent Effectiveness Training Manual which discriminates between effective and ineffective communication techniques in relation to parent-child interactions. He specifically deals with judgemental, evaluative parental attitudes and how they prevent active listening. It has been realized that instruction in communication patterns and listening skills has strengthened the parent-child bond and increased understanding within the family. The popularity of the parent training sessions is another example of the increasing demand.
for communication training.

Emphasis on marital and family communication patterns has become widespread. Satir (1972) has analyzed the family as a system and has described several communication patterns which often impede effective communication and create interpersonal problems. She maintained that these patterns of communication often become fixed and may result in a stalemate which prevents family growth and understanding. Miller, Nunnally, and Wackman (1975) have emphasized the differential aspects of interpersonal communication through their awareness wheel concept. They state that there are five different aspects which effect patterns in communication. These are sensations, thoughts, actions, feelings, and intuitions. Each factor needs to be examined in order to comprehend and facilitate a clear communication. They have also developed a manual which aims at the development of listening and receiving skills, and the proper discernment of the messages that are sent. This manual has been particularly applicable to marital, family, and other interpersonal relationships. Programs have also been established which concentrate on the relationship between parents and teachers. Particular attention to race relations as a factor in teacher-parent interaction has been given by Carkhuff (1969), as clear communication in this area is an important component in today's society.

Similarly, the need for good interpersonal relating skills amongst psychiatric patients has been suggested. Yet at present
few programs have actually been established. It appears to this author that training in the area of communications would be particularly beneficial to this population. Past research has demonstrated that increased communicative ability was positively correlated with an individual's life adjustment (Carkhuff, 1969). It has been noted that psychiatric patients are remarkably poor in listening and communicating skills. Ruesch (1951) wrote that schizophrenics were characterized by disturbed patterns of communication. He stated that people can be labeled as mentally healthy only when their ability to communicate allows them to manage their environment. He remarked further that by studying an individual's ability to communicate, one can judge the level of interpersonal functioning. Zigler (1962) reported a similar viewpoint, as he stated that the better the patient's social skills before hospitalization, the better the post-hospitalization adjustment will be.

This author has noticed that the psychiatric patient's orientation and preoccupation with subjective processes blocks effective communications. Partial receiving skills, faulty listening patterns and a tendency to encode statements negatively were common occurrences. Sending skills were also poor as inconsistent eye contact, blocked body position, and lowered voice tone indicated a paucity of interpersonal assets. Carkhuff (1969) maintains that dysfunctional communication is
a consequence of negative learning experiences and/or poor learning. It would therefore seem highly probable that an inpatient psychiatric population characterized by ineffective communication skills would benefit from systematic training in effective communication.

Rogers (1967) has observed that psychiatric patients can learn to differentiate warmth, genuineness, and empathy in therapist responses. They have also exhibited a greater degree of growth in response to these variables. This author believes that recognition of these qualities is an important first step in the formulation of any basic interpersonal skills.

Truax & Carkhuff (1965) presented patients with a videotape which provided a demonstration of a therapeutic session. In this session the patient explored his feelings and communicated these to the therapist. It was found that patients who viewed this film before therapy related in a clearer, more meaningful way to the therapist than their fellow patients who did not view the film. Therefore, a small learning of relating skill was exhibited. In another study Truax & Carkhuff (1966) found that those patients who were presented with the Vicarious Therapy Pretraining film demonstrated an increased change in self-concept towards the ideal concept as compared to the control group. The authors interpreted this change as a move in the direction of a greater personal and interpersonal
Recently other experimenters have focused specifically on teaching facilitative interpersonal relating skills to psychiatric patients. Pierce and Drasgow (1969) compared an experimental communication group with a medication only group, group therapy, and an individual therapy group. Five 1.5-hour sessions occurred over a five-day period. Measures revealed that the patients in the experimental group demonstrated a greater degree of improvement than the control groups on the dimensions of empathy, respect, genuineness, and concreteness. The psychiatric patients included in Pierce and Drasgow's experimental group gained several benefits from their interpersonal skills, these patients experienced a positive means of relating with each other. They built upon the positive qualities such as warmth and specificity, which are valuable tools in relating and understanding others. A posttest comparison rated the patients who received the experimental treatment as more helpful and understanding towards the other patients. This study implied that this training can be integrated with the patient's general relating ability.

Hersen & Bellack (1976) have also discussed the value of social skill training for chronic psychiatric patients. In comparing chemotherapy, socioenvironmental therapy, and a token economy system which reinforced the use of positive social skills, they reported that the latter was most effective. In a similar study McFall (1975) compared insight
therapy, assessment, and social skill therapy. Insight therapy was defined as the discussion of the feelings of the patient in regard to difficult interpersonal situations. In the social skill group role playing and specific advice to interpersonal relating problems were emphasized. The experimenters found a greater degree of improvement in the skill training group. Thus, the above studies have illustrated that communication skills can be usefully integrated in a ward situation by a psychiatric population.

Research has also demonstrated that several other factors should be controlled for as they effect outcome in communication training programs. These factors are a high functioning therapist, a blend of didactic and experiential material within the session, systematic training, and group context. Carkhuff, Pierce, and Berenson (1967) report differentiating effects for high versus low functioning therapists. A high functioning counselor was defined as an individual who was able to respond with level five empathic statements. He was considered intuitive and sensitive to the client's moods and feelings. It was found that counselors functioning on a higher level elicited more constructive gain from their students; the students were able to identify concerns with greater ease and achieve alternatives for problem solving. This finding was supported by Carkhuff, Pagell, and Berenson (1967). In their study they ascertained
that the clients who maintained the greatest improvement had high facilitative counselors. Even those clients who initially demonstrated a high level of interpersonal and behavioral functioning performed poorly when they were assigned a low functioning counselor. Therefore, the helper's empathic ability, honesty, genuineness, etc, is influential in its effect upon the patient's learning repertoire.

Another factor which has also been found beneficial in communication training is a blend of didactic and experiential material Carkhuff, Douds, and Truax (1964). It was postulated that the actual presentation of a learning paradigm combined with the opportunity to practice in an atmosphere of acceptance and safety were important factors in building communication skills. The authors of this study also maintained that high facilitative counselors were particularly effective in the experiential portion of this study as role models.

Research has also demonstrated that a systematic approach to communication training aids the patient in his ability to understand and apply the learned material (Carkhuff, 1969). The present training will provide the client with a hierarchy of behaviors such that he may experience positive reinforcement with the least difficult task. This strategy maintains and reinforces both the client's interest and the learning of new behavior. Behavioral rehearsal has
also been found to be an effective tool in effecting behavior change. In a study by Lazarus (1966) behavioral rehearsal was found to be significantly more effective as compared to non-directive therapy and advice. Therefore, role playing as a tool for assessment of communication deficits and skills and, for training within the communication group will be employed.

A further variable which effects communication training is the use of a group setting. Carkhuff (1969) writes that interpersonal problems result from dysfunctional communication. Therefore, training in communication is highly applicable in a group, interpersonal setting. While learning new communication skills, the patient has the opportunity to practice and receive positive feedback for his new found ability. "A high level of interpersonal functioning becomes both the means and the end of the helping process." (Carkhuff, 1969).

Gazda also supports the applicability of a group setting. He remarks that members are given the opportunity to act out characteristic behavioral patterns and receive appropriate feedback. In a task oriented group, members can interact with others in their new roles and receive feedback. Observation and a group criterion of social reality are also incorporated in the group procedure. Similarly Gordon (1970) has noted that parents in a group are often relieved when they realize that others experience and demonstrate similar communication patterns in relating to their children. One
can conclude that utilization of the group process in communication training is advantageous in building interpersonal skills.

The points just mentioned: High functioning therapist, a blend of didactic and experiential material within sessions, systematic training, and group context are influential in effecting a positive outcome of communication training and will be integrated in this study.

The communication training in this study will focus on the acquisition of listening and responding skills. Responding to content and to feeling will be explored. Accurate perception can be defined as the ability to attend, to recognize, and to understand the feelings and content that another person expresses verbally and/or behaviorally. This communication process is completed when the receiver incorporates the message and returns an appropriate response to the sender.

Traditional group therapy as employed in this study will consist of an exploration of feelings, thoughts, and goals in relation to the patient's present state. The author's theoretical background is a combination of Rational Emotive Therapy (RET) and communication theory.

It is the purpose of the present study to determine the need for communication training within a psychiatric inpatient population. A communication based group will be compared with traditional group therapy. It is hypothesized that the patients involved in the communication group will demonstrate a greater
increase in interpersonal relating skills than those involved in traditional group therapy. The independent variable is the treatment modality, namely communication training. The improvement in interpersonal relating skills is the dependent variable.
Method

Subjects: The patients in this study were selected from the Northwest unit of the Kalamazoo Regional Psychiatric Center. Initially, thirteen patients, two females and eleven males, were included in this study. However, during the experimental training, two male patients were discharged from the hospital. Also, one female patient from the communication group and one male patient from the traditional group refused to attend after the initial session. Therefore, the communication group consisted of one female and three male patients and the traditional group consisted of five male patients. These patients ranged in age from 25 years to 78 years. The mean age was approximately 49 years. All patients were Caucasian and came from a lower middle class background. All patients were diagnosed with a chronic disorder such as schizophrenia or psychosis. Each patient was presently stabilized through medication and through the hospital routine. The majority of patients had experienced at least three readmissions to the hospital within the last five years or had been living continuously at the hospital during this time. Four of the patients were allowed ground permits. The remaining five patients were residing on the locked wards. The majority of the patients were also involved in either occupational therapy, recreation therapy, or a work program.

Materials: The materials that were used throughout the study consisted of a blackboard, tape recorder, paper, pencils, and
mounted photographs from various magazines. The blackboard was utilized for the presentation of didactic material. Several tapes were made for use in identification of feelings, nonverbal inflections, response to feeling and content, and role plays. Paper and pencils were provided for group sharing exercises, and for notetaking. The photographs provided stimuli for nonverbal and feeling identification.

**Experimental Design:** Twenty-one patients were selected by the head nurse of the hospital as suitable for a group therapy situation. Criteria for this selection were absence of acting out behavior, ability or potential for conversation, absence of brain damage or minimal intellectual functioning, and an established level of self care (i.e. getting dressed, showing up for group).

One patient was eliminated from selection, as he was presently involved in group therapy. Seven other patients were also eliminated, as they had either departed from the hospital or were scheduled to leave within the next three weeks. The remaining thirteen patients were assigned to either the experimental group or the control group through a random selection process. The experimental group received training in basic communication skills. The patients in the control group were encouraged to explore their feelings, thoughts, and goals in relation to their present situation.

**Assessment:** Differences in outcome between the communication and traditional groups were measured by a written test designed
to determine the patients' level of functioning in basic communication relating skills. This test was adapted from a similar test used by Okun (1976). (See Appendix A for an illustration of the test). The test required that the patients answer in written form to various questions so that different patterns of responding could be established. For example one might respond with an empathic response, or a projection of internalized feelings. The statements constructed varied in emotional content and revolved around typical interpersonal and hospital situations. In the first section of the test the patients were provided with several responses for each statement. They were then asked to identify the response which they judged as most helpful. A response was defined as helpful if it was empathic and responded to the feeling and/or content of the speaker's statement. In the second section the patients were instructed to identify the affective components of several statements. Lastly, patients were required to write helpful responses to several given statements. This test was utilized as a pre and postmeasure for each group. It was administered within the group setting. The author read each question and prompted each patient to select or write a response. A few individuals progressed at their own rate. Each patient was allowed a maximum of 45 minutes to complete the test.

It was also decided that an oral component for assessment was needed. A series of role play situations were devised for pre and postmeasurement. (See Appendix B). A model role play was enacted between therapist and co-therapist before the
initial patient role play. Each patient was then given a role play situation and asked to act it out with another patient in the group. The other patient was designated as the helper and was directed to respond to the "client" in as helpful a manner as possible. Each pair was asked to dialogue until they felt the conversation was complete. At times the therapist prompted the "client's" statements. Each dialogue was recorded by tape and later each statement was rated by non-participant observers. An observation sheet was designed so that several categories were available for judgment. (See Appendices C & D for an illustration of the code sheet, and for a list of the operational definitions for each category).

Since nonverbal behavior is an important aspect of the communication process, a scale was developed to assess the patient's ability on each of the following dimensions: eye contact, occasional verbal comments, body position, facial animation, and nonverbal congruence. An observer was present during both pre and postmeasurement in order to rate each patient on the above dimensions. (See Appendices E & F for an illustration of the data sheet and for a list of the operational definitions for each dimension).

In summary, the performance of each group member was assessed by a written test, an oral-verbal situation, and an oral-nonverbal situation.

 Procedure: The communication group was trained during the months of November and December, while the traditional group met in January and February. Each group met for nine treatment sessions,
one session each Monday and Wednesday from 6:30 to 7:45. Each session of both groups consisted of a blend of didactic and experiential material. In the communication group the initial part of the session included a presentation of material, and attention to the homework assignment. The latter segment of the session was delegated to the practice and integration of the introduced concepts. Each session was planned to build skills for the next session, so that systematic learning and practice occurred. In the traditional group the initial part of the session also centered upon the introduction of didactic material. The latter part of the session focused on group sharing exercises related to the didactic. During both groups, patient involvement was encouraged during the didactic segment. The two groups differed essentially in content of the sessions. In the communication group each session focused specifically on a topic of communication: Attending, repeating content, responding to content, etc. Part of the session was used to practice these concepts. In the traditional group, topics were varied and basically consisted of mental health concepts: How to deal with anger, how to select goals, etc. These topics were then pursued in more detail by group members.

Both the communication and traditional groups were conducted by the author of this study and by two co-therapists who rotated attendance for each session. These co-therapists prompted the patients in participation in the didactic and also aided through prompting, confrontation, etc. in the experiential aspect of the session. Both co-therapists were well
trained individuals and had experience with a hospitalized population.¹

Both co-therapists also rated the author's performance on the following dimensions: Enthusiasm, warmth/caring, optimism, effort expended, persistence, and planning. (See Appendix G for an illustration of the rating scale). Since the author administered both treatments, all evaluations of therapist effectiveness were kept by each co-therapist until both treatments had been concluded. One of the co-therapists also acted as an observer for the nonverbal component of pre and post-assessment.

In addition to the use of co-therapists, two observers were selected to rate the verbal behavior of the patients during the role play situations. They were asked to judge the empathic ability, level of responses, etc. of the patients. Both observers were unaware of the experimental design and hypotheses. Both observers had been trained in Carkhuff responding and one observer had attended several Carkhuff trainings.

¹One has finished his masters in clinical psychology and the other has nearly completed her masters in social work.
Session 1 (Monday): The first session focused on the need for effective communication. A didactic was presented which dealt with faulty and selective listening patterns. The differences between effective and ineffective listening skills were outlined. Also the role that good communication skills plays in relationships was discussed.

![Diagram]

Several role plays were then presented which demonstrated both effective and ineffective listening skills. The patients were asked to decide which messages were effective. Two exercises were initiated to increase the patients' ability to recognize and recall the content area in conversational statements. First, each group member was asked to make a statement about his favorite hobby. After the first patient made a statement, the second patient next to him was asked to repeat the statement. Next, several statements were made to each patient. The patients were asked to repeat the content in each statement. Special attention was given to names, adjectives, adverbs, etc.

**Homework Assignment:** The patients were provided with several client statements. They were asked to identify and list the
factual components in each statement.

**Session 2 (Wednesday):** The factual components of the statements assigned for homework were reviewed. A didactic which analyzed statements as to their factual and feeling content was presented. Feelings as important factors in understanding and communicating with others were focused upon. Four main categories of feelings were outlined: Anger, sadness, fear and happiness. A list of additional adjectives were placed on the board through a group brainstorming process. Several taped statements were then presented to the group. Each patient was asked to repeat a statement and to identify the feeling associated with the statement. The adjectives listed on the board were used as cues.

In a second exercise each patient was asked to share with another group member something that had happened to him during the day. The respondent group member was then asked to repeat the statement and identify the feeling in the statement. The accuracy of the labeled feeling was assessed by the initial speaker.

**Homework Assignment:** The patients were provided with several statements and asked to identify the affective components in each statement.

**Session 3 (Monday):** Dysfunctional communication often stems from an incomplete awareness of ourselves. In this session a didactic was delivered which specified components that complete
our awareness. These components are thoughts, feelings, actions, and sensations. The concept of the awareness wheel was transformed here to an umbrella so that the idea could be easily conceived by the patients.

Figure 2

The affective components in the homework assignments were identified and reviewed. The four main feelings were listed on the board. The patients were asked to identify the nonverbal behaviors which usually indicate how feelings in others are recognized. The importance of nonverbals as part of our total awareness was emphasized. Below is a list of the nonverbal cues associated with the emotions listed.

Figure 3

<table>
<thead>
<tr>
<th>Anger</th>
<th>Happy</th>
<th>Sad</th>
<th>Fear</th>
</tr>
</thead>
<tbody>
<tr>
<td>frown</td>
<td>smile</td>
<td>frown</td>
<td>eyes darting</td>
</tr>
<tr>
<td>clenched fist</td>
<td>wink</td>
<td>eyes closed</td>
<td>body shaking</td>
</tr>
<tr>
<td>tight eyebrows</td>
<td>kiss</td>
<td>crying</td>
<td>mouth tight</td>
</tr>
<tr>
<td>narrowed eyes</td>
<td>arms open</td>
<td>avoids eye contact</td>
<td>eyes open</td>
</tr>
<tr>
<td>high, loud voice</td>
<td>hug</td>
<td>arms near body</td>
<td>rigid body</td>
</tr>
<tr>
<td>stamp foot</td>
<td>eyes open</td>
<td>shoulders slumped</td>
<td>quivering voice</td>
</tr>
<tr>
<td>shaking</td>
<td>body relaxed</td>
<td>head hanging</td>
<td>biting lip</td>
</tr>
<tr>
<td>tense body</td>
<td>face animated</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A series of pictures of different individuals were then
shown to the group, and each member was asked to identify the emotion shown in each picture. The patients also indicated what nonverbal behaviors helped them make their responses. The information on the board was used as a cue in this exercise. In a second exercise, the patients were required to act out nonverbally a feeling. The other group members then identified the feeling, and the clues which led to their response were discussed.

**Homework Assignment:** The patients were requested to watch and notice the facial movements, etc. of other patients and to identify how these nonverbals fit with their total awareness of that individual.

**Session 4 (Wednesday):** The nonverbals associated with the identification of emotions were reviewed. Next, a didactic concerning the reflection of feelings was presented. The acknowledgement and the acceptance of feelings in others are facilitative factors in effective communication. Without the perception and reflection of feelings, honest sharing is difficult. A modeling of the reflection of feelings was also presented. Several taped statements were then played to the group. Each member was asked to respond to the statement by using the prompt "You feel." In a second exercise, each patient made a statement about his activities during the day. Another member was then asked to respond with a "You feel" expression. Both these exercises were designed to facilitate the responding to feeling expression. A general conversation
exercise was then pursued in which each person expressed the factors that make him angry. The respondent then repeated the speaker's statement. This exercise was included to practice listening skills.

**Homework Assignment:** The patients were given a list of statements and were instructed to write an affective response to each one.

**Session 5 (Monday):** Inappropriate responses can also block effective communication. In this session, a didactic was presented which focused on the responses which impede or confuse the speaker. Such responses as ignoring, advice, interrupting, personalizing, criticizing, intellectualizing, and exaggerating were discussed. The factors which contribute to the inappropriateness of these responses were also analyzed. Pairs of taped statements were presented to the group. Each member was instructed to identify the response as appropriate or inappropriate. If inappropriate, the response was then identified as belonging in one of the above categories. A second exercise was initiated to focus again upon nonverbals. Each patient was asked to make a statement, and another group member was instructed to mimic the statement and how it was delivered. Then a general conversation exercise followed in which each patient made a statement about himself, and another member responded in the "I heard you saying that ___" format. The previous homework assignment concerning responding to the affective component was reviewed.
Homework Assignment: A list of statements were provided, each statement having several possible responses. The patients were asked to choose the appropriate response.

Session 6 (Wednesday): The types of appropriate and inappropriate responses as discussed in Session Five were briefly reviewed in conjunction with the homework assignment. The response which combines both affective and factual components was discussed and modeled in a role play by therapist and co-therapist. Then partners were formed within the group. One partner was given an imaginary situation and asked to converse about it. The other partner was instructed to respond with a statement based on the following format: You are feeling _______ because _______. The partners were urged to make at least three statements and responses. Then the partners switched roles. Next, an exercise was initiated in which a member made a statement about his activities during that day. The next patient was then asked to respond in the "You are feeling _______ because _______" format. Feedback from the first person was used to clarify the appropriateness of the response. A general conversation exercise was employed to conclude the session. Each patient was asked to talk about their personal meaning for Thanksgiving. Listening skills amongst other group members were checked at this point.

Homework Assignment: Several statements were given, each listing below four feeling words. The patients were asked to circle the feeling word which best described the affective
content of the statement.

Session 7 (Monday): A brief review of how nonverbal behaviors affect our interactions was pursued by writing descriptions of several nonverbals on the board. Group members were then asked to determine how that individual might be feeling. For example, if an individual has a tense body squinty eyes, pointed hand, and loud voice, then he is feeling angry.

Next a presentation concerning the positive and the negative aspects of nonverbal behaviors on the part of the helper were given. Figure 4 lists these behaviors.

<table>
<thead>
<tr>
<th>Helping</th>
<th>Nonhelping</th>
</tr>
</thead>
<tbody>
<tr>
<td>tone of voice similar to helpee's</td>
<td>unpleasant voice tone</td>
</tr>
<tr>
<td>good eye contact</td>
<td>frowning, scowling</td>
</tr>
<tr>
<td>occasional head nodding</td>
<td>tight mouth</td>
</tr>
<tr>
<td>facial animation</td>
<td>shaking pointed finger</td>
</tr>
<tr>
<td>occasional smiling</td>
<td>distracting gestures</td>
</tr>
<tr>
<td>occasional hand gesturing</td>
<td>sitting too far apart</td>
</tr>
<tr>
<td>appropriate physical distance</td>
<td>too slow or too fast speech</td>
</tr>
<tr>
<td>moderate rate of speech</td>
<td>closing eyes or looking away from the speaker</td>
</tr>
<tr>
<td>body leans toward helper</td>
<td></td>
</tr>
</tbody>
</table>

The effect of positive nonverbal behaviors on developing positive communication skills was stressed. Several pictures of people in interactions who were demonstrating nonverbal behaviors were shown to the group. Each member was asked to describe the relationship which existed between the individuals in the picture. Then with the material on the board as a cue, the group member was asked to mention which specific nonverbal behaviors helped him realize the nature of the communication.
In the next exercise the patients were again placed in a role play situation in which the helpee was required to respond with a "You feel _______ because _______ statement." In addition special attention and feedback was provided by the therapist and co-therapist concerning the nonverbal behaviors presented by the patient during the role play. A general conversation exercise concluded the session. Each patient was asked to discuss one good event which occurred over Thanksgiving weekend. Another group member was then asked to converse with the speaker concerning his statement.

**Homework Assignment:** The patients were given a list of statements and instructed to write a response to each one, employing both affective and factual components.

**Session 8 (Wednesday):** The homework assignment was reviewed. The appropriate and inappropriate aspects of responding plus the positive nonverbal behaviors were reviewed by the group using the brain storming process. Then several pairs of taped statements were presented to the group. Each member was asked to decide whether the response was appropriate or not. If the response was inappropriate, then the member was instructed to respond to the statement using the appropriate response format. The last exercise was again directed toward basic listening skills and conversation exchange. Each member was asked to describe one positive and one negative
behavior about themselves.

**Homework Assignment:** The patients were given a list of statements and instructed to write a response to each one, employing both affective and factual components.

**Session 9 (Monday):** Mixed messages are often apparent when a discrepancy between verbal and nonverbal behaviors occurs. A lecture on these messages and how they affect the communication process was delivered. The therapist and co-therapist modeled the ways to break or confront a mixed message. Each patient was then given a slip of paper which contained a statement. The patients were asked to read out their statement, using the appropriate nonverbal behaviors. Any discrepancies between verbal and nonverbal messages were discussed.

A brief review of appropriate responding and positive nonverbal behaviors was integrated with the homework at this point. Then the patients were again divided into partners and each patient was placed in a role play situation. The helper was instructed to give several appropriate responses. If the helper experienced difficulty, other group members were asked for feedback. This session concluded with a general conversational exercise in which each patient was asked "If you could change something in the hospital, what would it be?". Each group member was asked to repeat or comment upon the other's statement.
Treatment 2

Session 1 (Monday): Several warm-up exercises were conducted to increase the comfort level of the group and to aid in future sharing. Then each patient was asked to describe or show how he looks when he is pleased with something and how he looks when he is angry or upset. A general discussion of nonverbals and how they portray feelings was developed.

Session 2 (Wednesday): This session also began with a warm-up exercise. A didactic concerning the relationship between feelings and thoughts was presented. Figure 1 was illustrated on the board.

![Figure 1](image)

One patient had displayed some anger in group. This situation was used as an example, and the group participated in exploring the thoughts which might have led to his feeling of anger. Each individual was then asked to recall the last time that he was angry. Each situation presented was interpreted from a cognitive viewpoint. Group commentary was again encouraged.
Session 3 (Monday): A review of the thought feeling model occurred. Then the group was asked to list constructive and destructive ways of handling anger or other emotions. This information was placed on the board. The patients were encouraged to give concrete examples about how they handle anger so that the didactic could be personalized. Another group exercise was then initiated. Each member was asked to write on a piece of paper his inner resentments. Each piece of paper was folded and placed into a paper bag. Then the slips were drawn randomly and each individual read the statements from the slip that he had chosen. Resentments and our ways of containing them were discussed.

Session 4 (Wednesday): In this session the nicknames that we have and their implications were discussed. This exercise led to further ideas about the aspects of self which are liked and those which are disliked. Changes that can be made were reviewed.

Session 5 (Monday): Goals as important factors in the pursuit of needs and desires were the topic of this session. Short, immediate and long term goals were discussed. A typical goal was placed on the board and means for pursuing it were obtained through a brainstorming process. A more personally oriented discussion of goals was then initiated.

Session 6 (Wednesday): The didactic on goals was reviewed briefly. Each patient was then handed a piece of blue paper and a piece of pink paper. The patients were instructed to
write a short term goal which could be accomplished while in the hospital. The blue paper symbolized a fun oriented goal. The patients then read their goals and these were discussed within the group. The needs that these goals fulfilled, how they could change the patients situation, how they fit with long range goals, etc. were among the points touched upon during discussion.

Session 7 (Monday): The discernment of nonverbals is important in our daily contacts with others. How we evaluate our interpersonal relationships is influenced by nonverbal cues. A didactic was pursued in this session which focused on nonverbals and their effects. Several nonverbals were placed on the board and described as pleasant or unpleasant by the group. A group exercise was then initiated: All the names of the patients were placed in a bag. Each patient then drew the name of someone else and was asked to imitate that person nonverbally. This exercise prompted insight into the way the group members viewed each other. The acceptability of such viewpoints was also investigated.

Session 8 (Wednesday): A warm-up exercise which emphasized listening skills initiated the session. A brief review of the previous didactic occurred. A group of photographs were placed on the table. Each patient was then asked to relate a story about the pictures that he had chosen. Significant points were commented upon by the therapist and co-therapist.
Session 9 (Monday): Each patient was told that he could run the group for a few minutes or could state what he would like to accomplish as a group leader. The patients were then placed in role play situations. The conversations were taped and replayed. The therapist halted the tape and commented upon significant statements. Group participation was again encouraged.
RESULTS

Outcome Between Groups

A communication group was compared with traditional group therapy. It was hypothesized that the communication group would produce a greater change in appropriate responses. Outcome as a function of treatment differences, was compared along three dimensions: Written test, role play situations, and nonverbal factors. A t test was conducted on the gain scores of each group member. In this way any differences in pretest scores between groups were hopefully eliminated. The communication group demonstrated a slight, although non-significant, increase in communication skill learning, as compared to the traditional group on the written test measure, t (7) = 1.7571, p < .10. Figure 1 illustrates outcome for the communication group and the traditional group. A lack of significance between groups was found on the role play measure, t (7) = .6486, p > .05 and on the nonverbal measure, t (7) = .7371, p > .05. Therefore, none of the measures of outcome demonstrated a statistically significant change between treatment.

Outcome Within Groups

Comparisons of change between pre and postconditions for each group were also conducted. Both mean change and change in percentage of appropriate responses were analyzed for the written test and role play measures. In the communication
Figure 1: Percentage of correct responses as measured by the communications skills test for groups 1 and 2.
group a significant increase in correct responses for the written test was found, $t(3) = 3.7282, p < .05$. Similarly, in the traditional group a significant increase in correct responses for the written test was found, $t(4) = 2.1495, p < .05$. Therefore, it was concluded that the treatment component was an effective change agent for each group. However, the communication group showed a greater degree of improvement as compared to the traditional group. Tables 1 and 2 indicate the percent of correct responses as measured by the communication skills test. In comparing the percent of responding between groups. The patients in the communication group showed a 30% increase in responding between pre and postconditions. The patients in the traditional group demonstrated a 19% change in correct responses. Both groups experienced a similar percent of the correct responses in the pretreatment measure.

Figure 2 illustrates the percent of appropriate responses as measured by the role play situations for Group 1 and Group 2. A significant increase between pre and postconditions was found in the communication group, $t(3) = 4.6948, p < .05$. Thus the communication training affected a change in the number of appropriate responses. In the traditional group a lack of significance was found for the number of appropriate responses, $t(4) = .9302, p > .05$. It appears that the traditional group did not create an increase in appropriate responses as measured by the role play situations. This disparity between the communication and traditional groups becomes more apparent.
Figure 2: Percent of Appropriate Responses as Measured by Role Play Situations for the Communication and Traditional Groups.
by investigating the percent of appropriate responses. Tables 3 and 4 display the percent of appropriate responses for the patients in each group. Table 5 presents the total number of responses for Groups 1 and 2. The total number of responses for the communication group remains nearly equal. However, the total number of responses for the traditional group increases from a pretest level of 23 to a posttest level of 63. Therefore, even though the traditional group produced a greater number of responses during the posttest phase, a reduction in appropriate responding was found.

Mean change for nonverbal factors was compared between pre and postconditions for each group. In the experimental group a lack of significance between pre and postconditions was found \( t(3) = 2.1676, p > .05 \). A similar lack of significance was found for the traditional group, \( t(4) = 2.000, p > .05 \). The tabled values indicate that the mean level of nonverbal functioning was similar for both groups. It appears that treatment efforts for both groups were not significantly directed towards nonverbal factors.

Factors Connected with Appropriate Responses

Within the role play situation a variety of other factors were found to be important. These factors are activity level, action latency, and positive responding. The total amount of verbal behavior expressed designated the activity level. It was found that this factor increased greatly over pre and postconditions within the traditional group. The activity level included both appropriate and inappropriate responses.
Table 1. Percentage of Correct Responses as Measured by the Communication Skills Test for the Communication Group.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Pre</th>
<th>Post</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>S₁</td>
<td>34%</td>
<td>63%</td>
<td>29%</td>
</tr>
<tr>
<td>S₂</td>
<td>26%</td>
<td>34%</td>
<td>8%</td>
</tr>
<tr>
<td>S₃</td>
<td>43%</td>
<td>88%</td>
<td>45%</td>
</tr>
<tr>
<td>S₄</td>
<td>11%</td>
<td>51%</td>
<td>40%</td>
</tr>
<tr>
<td>Total</td>
<td>29%</td>
<td>59%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Table 2. Percentage of Correct Responses as Measured by the Communication Skills Test for the Traditional Group.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Pre</th>
<th>Post</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>S₁</td>
<td>20%</td>
<td>26%</td>
<td>6%</td>
</tr>
<tr>
<td>S₂</td>
<td>31%</td>
<td>34%</td>
<td>3%</td>
</tr>
<tr>
<td>S₃</td>
<td>29%</td>
<td>31%</td>
<td>3%</td>
</tr>
<tr>
<td>S₄</td>
<td>49%</td>
<td>69%</td>
<td>20%</td>
</tr>
<tr>
<td>S₅</td>
<td>9%</td>
<td>43%</td>
<td>34%</td>
</tr>
<tr>
<td>Total</td>
<td>28%</td>
<td>47%</td>
<td>19%</td>
</tr>
</tbody>
</table>
Table 3. Percent of Appropriate Responses for the Communication Group as Measured by Role Play Situations.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Pre</th>
<th>Post</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>S₁</td>
<td>0%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>S₂</td>
<td>50%</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>S₃</td>
<td>14%</td>
<td>20%</td>
<td>6%</td>
</tr>
<tr>
<td>S₄</td>
<td>50%</td>
<td>17%</td>
<td>-33%</td>
</tr>
<tr>
<td>Total</td>
<td>29%</td>
<td>52%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Table 4. Percent of Appropriate Responses for the Traditional Group as Measured by Role Play Situations.

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Pre</th>
<th>Post</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>S₁</td>
<td>25%</td>
<td>16.6%</td>
<td>-8.4%</td>
</tr>
<tr>
<td>S₂</td>
<td>20%</td>
<td>16%</td>
<td>-4.0%</td>
</tr>
<tr>
<td>S₃</td>
<td>33%</td>
<td>0%</td>
<td>-33.0%</td>
</tr>
<tr>
<td>S₄</td>
<td>13.3%</td>
<td>15%</td>
<td>1.7%</td>
</tr>
<tr>
<td>S₅</td>
<td>50%</td>
<td>16%</td>
<td>-34.0%</td>
</tr>
<tr>
<td>Total</td>
<td>26%</td>
<td>15%</td>
<td>-11.0%</td>
</tr>
</tbody>
</table>
Table 5. Total Number of Responses for Both Groups Across Pre and Postconditions.

<table>
<thead>
<tr>
<th>Time</th>
<th>Communications Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Post</td>
<td>25</td>
<td>63</td>
</tr>
</tbody>
</table>
This increase was not demonstrated in the communication group.

Action latency was defined as the amount of elapsed time before the helpee responded to the verbal behavior of the "client." This corresponds to prompting which was a comment made by the therapist urging a "client" to respond to the helpee. It was found that both prompting and action latency decreased for both groups between pre and postmeasures. Therefore, as a result of treatment, the patients felt freer to express themselves and were able to respond within a 10-second period while conversing in a role play situation. This result was particularly exceptional for one patient who had not been able to respond or to initiate responses during the pretest unless prompted.

Positive responses as a measure of appropriate responding were also investigated. A positive response was defined as a response or comment which was judged as encouraging or as an agreement to a positive response by a "client." Advice, although positive, was not included in the definition. It was found that the number of positive statements increased slightly for both groups between pre and post measures.

Reliability Measures

The reliability of therapist effectiveness between groups was measured by an analysis of variance test. As predicted, a lack of significance between groups was obtained, F (1,10) .5036, p > .05. Therefore, the therapist had been judged as equally effective for both groups. It is felt that this statistical support is necessary and important to the study since
the author conducted both the communication group and the traditional group.

Inter-observer reliability was calculated for the pre and posttests of both groups. Table 6 illustrates the obtained values of reliability. The inter-observer reliability for both groups was lower than expected, falling within the 70-80% range of agreement. However, a higher level of agreement was reached through collapsing the categories into two main areas: appropriate responses and inappropriate responses. Table 7 presents the agreements reached. The inter-observer reliability at this point was approximately 95% under both conditions for both groups. This appears satisfactory, as the statistical inferences were based on the broad category of appropriate responses.
Table 6. Inter-Observer Reliability for Pre and Postconditions for Both Groups.

<table>
<thead>
<tr>
<th>Time</th>
<th>Communication Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>74%</td>
<td>83%</td>
</tr>
<tr>
<td>Post</td>
<td>72%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Table 7. Inter-Observer Reliability for Generalized Categories for Both Groups.

<table>
<thead>
<tr>
<th>Time</th>
<th>Communication Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td>Post</td>
<td>88%</td>
<td>96%</td>
</tr>
</tbody>
</table>
Discussion

A group trained in communication skills such as attending, listening, and responding was compared with a traditional therapy group. It was hypothesized that the communication group would effect a greater increase in appropriate communication responses as compared to the traditional group. The results indicated a lack of significant differences in outcome between the traditional and communication groups. Several conditions may have contributed to this lack of significance. One condition may be that the interpersonal relating which occurred in the traditional group was sufficient in creating an improvement in communication skills. The traditional group was structured so that patients were required to listen to other group members. They were encouraged to respond, ask questions, and give feedback within the group. These activities emphasized the need for communication skills. The experiential aspect of treatment within the traditional group seemed to influence the patients practice of communication skills. Therefore if a no treatment control group had been added in this study, the effects of treatment alone could have been more accurately assessed. This addition would increase the power of the design.

Another condition which may have influenced the lack of significance between groups is the structure of the treatment groups. The design of this study intended that both treatment groups be composed of a didactic and experiential segment for
each session. Each group was structured so that an initial didactic was followed by experiential exercises in which patients either pursued communication skill exercises such as repeating feelings, responding to content as in the communication group, or shared feelings, goals, problems with anger, and were prompted to provide feedback to other group members as in the traditional group. It was felt that the content of the communication group would be sufficient to produce a significant difference in appropriate responding between the communication and traditional groups. However, it appeared that a similar practice of communication skills was initiated by the unintended similarity of structure of both groups. In this way the complementary structure may have contributed to the similar effects of treatment.

A third condition that should be discussed is the differences in client composition between groups. Although the pretest measures for the written test, role play situations, and nonverbal factors were similar, a qualitative difference in group composition must be considered. It was observed by this author and co-therapists that the communication group members were much slower in responding than the traditional group members and did not participate as well in didactic presentations. The communication group members were more likely to hallucinate during the group sessions. It would be noticed that they would often mumble to themselves or attempt to rise and move around the room. Also the communication group members were also experiencing some difficulty
with their medication. One communication group member was extremely sedated and two other patients in the communication group had to adapt to changes in their medication. In contrast the traditional group members were stabilized to their drug dose. Several of the patients in the communication group had to be urged each time to attend group. They would say that they had aches or were hearing voices. However, the traditional group members needed no prompting and always reported for group on time. Therefore, the level of resistance within the communication group members may also have affected the quality of group composition.

Similarly, each patient in the communication group missed at least one session and two patients missed two sessions. A perfect level of attendance was recorded for the traditional group members. Attendance at each session was particularly important for the members in the communication group as each didactic built upon the skill acquired in the previous session. For example, responding to content followed repeating of content, etc. When a patient missed a session, it became more difficult to follow and accomplish the sequence of communication skills. Therefore, it appears that even though the patients demonstrated a quantitative equality on pretest measures, the communication group was qualitatively handicapped.

A final condition which may have influenced the absence of significant differences between treatments is the methods used for measuring outcome. These measures included a written
posttest, and observations of verbal and nonverbal behavior in a role play situation. The written test used in this study is not a standardized instrument and may need further refinement to increase its sensitivity to treatment differences. For example the vocabulary could be simplified to aid understanding as the bizarre thought processes of the patients produced a blocking on certain words in the test. Also the statements could be made more applicable to a chronic population. Since the patients had been within an institution for a period of time, they had some difficulty in associating to situations concerning job difficulties, raising children, etc. This may have decreased their ability to respond appropriately. Finally the responses were similar in emphasis. For example "That's too bad" is somewhat similar to "You feel scared right now." More advice and critical responses could have been devised to create a more obvious difference between appropriate and inappropriate responses.

The role playing situation as a measure of outcome could also have improved to detect differences in treatment. This could be accomplished by observing a group member in a variety of different role play situations. In this way the patient could respond to several different content areas and he could be observed several times. It might also be beneficial to observe the patient throughout treatment and not only at the termination of treatment, as results would then be based upon a larger sample of the patients' behavior.
Another variable within the role play situation which might be altered is the partner used for each role play. Each patient was randomly assigned a partner from the group. However, some group members were more oriented to reality in that they were able to aid their partner by responding in complete sentences with recognizable, logical thoughts. This method of responding facilitated conversation as compared to the low functioning members whose thinking was tangential, illogical, and sometimes bizarre. For example one low functioning member responded "puzzle me out" as a way of saying "I'm confused." Therefore, the potential responding behavior of some patients was not well attuned to reality. It might have been beneficial to use the co-therapist as a partner for each patient. In this way each individual would be provided with more concrete, understandable responses.

A final condition which may have affected treatment is the use of the same therapist for both groups. Results demonstrated an equality of treatment skills delivered between groups. Therefore, each group received similar services. However, if another therapist with equal but dissimilar skills had been employed, a difference between treatments may have been detected.

In summary then it has been discussed that several factors may have influenced the lack of significance between treatment groups. These factors are: (1) the presence of treatment, (2) a similarity in structure between the two treatments, (3) qualitative differences in client composition, (4) methods utilized for measuring outcome, and (5) use of one therapist for
delivery of both treatments. It also seems apparent that the material presented in the communication training group was not fully incorporated. If reinforcement for attending sessions, completing homework assignments, and participation in group had been available a greater learning might have occurred. For example, during one session a patient who was noted for his inability to concentrate, stated that he would listen well if someone would buy him a coke.

In a recent study by Tracey (1974) behavioral strategies were designed to increase positive statements within an inpatient psychiatric population. Through the use of a token economy system positive statements about activities (recreation therapy, occupational therapy, etc.) were increased. It was found that an increase in positive statements also led to an increase in participation in activities while the token economy system was maintained. Thus, the use of similar strategies could have strengthened the communication program in this study.

Both groups demonstrated a statistically significant increase in appropriate responses as measured by the communication skills test. Therefore, it appears that both treatments were effective in producing a written behavior change. However, only the communication trained group demonstrated a statistically significant change in responding as measured by the role play situations. A visual inspection of Figure 2 reveals an interaction between the two treatments. The constraints of a small sample limit any interpretation of this
interaction. It was found that the communication group emitted a greater proportion of appropriate responses as compared to total responses. An appropriate response was defined as a response which was empathic and/or reflected content or affect of the speaker's statement. The traditional group produced a greater amount of responses, but the actual number of appropriate responses appeared to be reduced because of the increase in responses. In summary then the communication group produced more appropriate responses and the traditional group produced more total responses. This difference may be attributed to a difference in treatments. The communication treatment consisted of learning and rehearsing specific communication skills. The traditional treatment emphasized the sharing and open discussion of feelings, thoughts, etc. This open sharing produced an increased comfort level within the group which facilitated the production of a greater number of responses. It may be hypothesized that if more sharing, flexibility in structure, and openness were incorporated in the communication group, a greater total number of responses might have been achieved. With a greater number of responses, one can conjecture the presence of more appropriate responses as a result of the specific skill training. This would lead to a significant difference in appropriate responding between groups. Therefore, it may be advisable to incorporate a greater degree of sharing and exchange within the communication group.
Lastly, a lack of significant change in nonverbal factors was found for both groups. It was expected that the patients would have incorporated an open body posture, direct and steady eye contact, a high number of nonverbal comments, etc. This lack of significant difference was due to an absence of concentration upon these factors within the program. The importance of nonverbals was stressed through the didactics in both groups. Yet considerable practice and attention to nonverbals was not included in the communication group due to the limited conceptual ability of the patients. Each verbal skill took more time for practice and explanation than expected. Therefore, nonverbals were not emphasized. However, since these factors are so important in the communication process, it would be recommended to include them for future programs. Although a slight change in other factors such as action latency, prompting, etc. occurred, it would be advised that attention to these factors would also aid in increasing the patients skill in communication.

Summary
1. Differences in treatment between the communication and traditional group did occur, although they were statistically nonsignificant.
2. Both groups demonstrated a statistically significant increase in appropriate responses as measured by the written test.
3. Neither group demonstrated a qualitative improvement in nonverbal responding.
4. Communication group patients showed a statistically significant improvement in the category of appropriate responses as measured through the role play situations.

Recommendations

In establishing communication skill programs it is recommended that:

1. Differences in structure as well as content should be incorporated.

2. A greater allotment of time be considered for the sharing feelings, thoughts, etc. This flexibility may increase the number of responses obtained.

3. Repeated measures of role play situations be utilized for an accurate assessment of outcome.

4. A communication skills test be sensitive to the needs and understanding of the population with which it is employed.

5. Attention to measures by nurses and other ward personnel are needed to assess generalization from group to ward situations.

6. Utilization of behavioral strategies such as tokens for correct responses might be effective in producing a greater number of appropriate responses.

7. Orientation to the individuals unique communication deficit might increase the therapeutic effectiveness of the program. For example one individual may need to work on listening skills, while another may need to concentrate on responding skills.
Appendix A
Communication Skills Test

I'd like you to imagine that the statements below are from someone who has come to you for help. Pick the best answer to the statements listed below.

Example: This is an uncomfortable place to be. I want to leave.

a. Well, why don't you leave.
b. It seems really strange for you here and you'd like to leave.
c. Oh, you'll get used to it soon.

Sentence b is correct because it reflects the feeling and content of the speaker's statement.

Now here are some examples for you to try!

1. The people around here really piss me off. I've been sitting on this ward for a week and I still haven't seen the doctor.

a. I know how you feel. It's terrible.
b. I'm really pissed at the doctor too. Let me tell you what's happened to me.
c. You seem really angry because the people here aren't considering your feelings.

2. Sometimes I feel so alone. It's so difficult to talk to other people.

a. Well, work at it and you can do it.
b. I think that happens to everybody.
c.  Hmmm, it sounds like you feel down and out because it's hard for you to relate to others.

3.  I'd love to go back to work, but my husband feels that I should be home with the kids.
   a. I can see that. Mothers should be with their kids.
   b. You're not sure whether to work or to stay at home.
   c. Seems like you feel angry towards your husband because he's imposing his expectations on you.

4.  People today care more about money than they do about each other!
   a. You feel scared that people don't care for you.
   b. It makes me angry too, that people are materialistic.
   c. Well, that's the world we live in.

5.  My husband just called and told me that he and the kids miss me. That was nice of him: I feel good now, just hearing that.
   a. You feel reassured that your husband and kids love you and that feels comforting to you.
   b. Are you sure he meant that?
   c. I wish my husband would call me, but then he's a real pain anyways.

Part 2: I'd like you to read each statement and write down some feelings that you think that person is having.

Example: I just took a long walk. It's so nice out tonight. I could smell the grass and the flowers. I feel great.
She's feeling - relaxed, happy, excited, content, worthwhile.

Now here are some examples for you to try.

1. That woman is stuck in a wheel chair and never speaks to anyone.

She's feeling -

2. Tomorrow I get out of here. I'm getting my old job back and my wife is having a celebration dinner.

He's feeling -

3. Here comes Jill again. She's probably after another cigarette for the fifteenth time today.

He's feeling -

4. Boy, he's a good looking therapist! I wish they had more men like him around, then maybe I'd enjoy therapy.

She's feeling -

5. My husband yells at me all the time. I never say anything, it just isn't worth it!

She's feeling -

Part 3: You are working hard. Only one more part left. Now someone has come to you for help. Try to be as helpful and positive as possible. Here are some statements. In the blanks provided, write down a response that you think is helpful.

Example: Tomorrow I go to court. I can't sit still right now just thinking about it.

Response: I sense you're really scared about what might happen in court tomorrow.

1. I just came back from eating with my husband. It felt
really strange being on the outside. I just felt so uncomfortable. I don't know if I want to go out again.

Response:

2. I went to the dance we had last night and met this guy from another ward. He's really nice. I haven't felt this good in a long time.

Response:

3. I really envy Ginger. She seems to have everything she wants, a good home and a husband who loves her. What went wrong in my life?

Response:

4. My husband wants to visit me. I just don't think I can handle that right now. Yet, I do miss him so much.

Response:

5. At night I can't get to sleep and during the day I feel so worn out that I can't do a thing. I feel like I'm on some kind of treadmill.

Response:
Appendix B
Role Play Situations

1. A man is growing bald and he is certain that no one will ever be attracted to him again. He is afraid to talk to others because he feels that they are laughing at him behind his back.

2. Julie just gained twenty pounds and can't find a dress to fit into. She's upset that she is so fat and doesn't want to leave the house. Yet she just got invited to a party.

3. John's daughter is 16 years old. He had warned his daughter not to fool around because he did not trust her or her boyfriend. Yet, yesterday she told him that she is pregnant. He is furious with her.

4. Sally is about 68 years old. She is pretty much alone in this world. She just found out that her SSI check has been cancelled. At this moment she doesn't have any money and feels pretty helpless about the whole situation.

5. Tom came home from fishing and found a note from his wife saying that she was leaving him. They have been married for 20 years and he had no idea that she was dissatisfied. He feels hurt and wonders what went wrong.

6. Marianne told her son not to use the car. Well, he took it and went out drinking. He totaled the car and she is furious with him.

7. Jim has one leg which is shorter than the other. He can't
play kickball with the kids and they call him names like "gimp." Sometimes he just hates school and feels so lonely.
Appendix C

Data Sheet for Verbal Observation

Observer: _______________________  Subject: _________________
Date: _______________________  Activity: _________________
Sheet: _______________________  

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Appendix D

Definitions of Observational Terms

**Empathic Agreement (EA)** - a general empathic remark which does not respond specifically to feeling or content. i.e. "That's too bad."

**Repeating Feeling and/or Content (REP)** - a response which simply repeats a feeling or content statement.

**Responding to Feeling (RES-F)** - a statement which responds with a feeling word similar to that used by the first speaker. i.e. $S_1$: I am depressed.
$S_2$: You feel down and out.

**Responding to Content (RES-C)** - a statement which summarizes and/or reflects the facts uttered by the first speaker. i.e.
$S_1$: There are fifteen kids in my family.
$S_2$: You come from a large family.

**Responding to Feeling and Content (RES-F&C)** - a statement which both responds to the feeling and content uttered by the first speaker. i.e.
$S_1$: I just got a promotion at my job; I'm thrilled.
$S_2$: You're happy that you are moving up at your job.

**Appropriate Question (AP-Q)** - an inquiry (direct or indirect) which pursues the content or feeling statement made by the first speaker. The question should be stated in a positive manner. i.e.
$S_1$: I am not sure if my husband wants me home.

$S_2$: You don't feel secure about your reception at home? (indirect)

$S_3$: How come you aren't sure about your husband? (direct)

**Inappropriate Question** (IAP-Q) - an inquiry is posed which does not follow the immediate content and/or feeling of the first speaker's statement. i.e.

$S_1$: I am worried about leaving the hospital.

$S_2$: How come you are leaving the hospital?

or an inquiry which is negative and implies derogation of the speaker. i.e.

$S_1$: I am worried about leaving the hospital.

$S_2$: What does someone like you have to be worried about?

**Advice** (AD) - a statement in which the first speaker is told what to do. A solution is offered. i.e.

$S_1$: My sister has really hurt me.

$S_2$: You should forget about her.

**Opinion** (OP) - a statement which responds to content and/or feeling partially through the respondent's internal frame of reference. i.e.

$S_1$: I want to leave as soon as I can.

$S_2$: All hospitals are awful.

**Ignore** (IG) - a response is scored as ignored when a reaction is not elicited within a ten second interval. However, if the speaker does not leave time for a response (talks continually), then no response can be expected.
**Interrupt (IPT)** - the respondent does not allow the speaker time to finish his own statement.

**Change Topic (CH-T)** - a statement which does not respond to content or feeling as the respondent introduces a new topic. Often this topic refers to personal issues and is self-oriented. i.e.

S₁: I'm worried about leaving the hospital.
S₂: Tomorrow I go to court.
Appendix E

Data Sheet for Nonverbal Observation

Observer: _______________   Subject: _______________
Date: _______________   Activity: _______________
Sheet: _______________

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Appendix F
Definitions of Nonverbal Terms

**Eye Contact** - occurs when the respondent directs his eyes towards the upper region of the listener's face. The longer the length of eye contact or the greater the number of occurrences of eye contact, then the greater the numerical score given to the respondent.

**Occasional Verbal Comments** - are nonstructured sounds such as hmm and uh-huh uttered in a confirmatory manner. The more comments produced in a session, the greater the numerical score given to the respondent.

**Body Position** - is the angle at which the respondent's body is in relation to that of the listener. A body position of 45° slant or more away from the listener would be assigned a low numerical score. A body position at a neutral angle of 90 degrees would be assigned a medium score, and a body position of 45 degrees or more towards the listener would be assigned a high score.

**Facial Animation** - are expressions which convey interest such as upraised eyebrows, open eyes, uptilted head position and mouth movement. These expressions would receive a high rating. Half-shut eyes, droopy head, tight mouth, and placid muscles around the jaw are expressions which would indicate low facial animation.
Nonverbal-Verbal Congruence - is a parallel between listener's content statement and respondent's nonverbal expression. An example of congruence would be a nodding of the head or murmered acknowledgement to the statement "I am very depressed today." However, if the respondent chuckled or giggled, this would be considered incongruent and would receive a low numerical score.

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Appendix G

Therapist Evaluation

On a scale of one to five, one being the lowest and five the highest, rate the therapist on the following variables:

1. Enthusiasm 1 2 3 4 5
2. Warmth/Caring 1 2 3 4 5
3. Optimism 1 2 3 4 5
4. Effort Expended 1 2 3 4 5
5. Persistence 1 2 3 4 5
6. Planning 1 2 3 4 5

Observer: _______________________  Group: ____________________
Date: _________________________
Session: _______________________
References


